

What Happens to the Women who Fall through the Cracks of Health Care Reform? Lessons from Massachusetts

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Objectives

In 2006, the Commonwealth of Massachusetts passed legislation aimed at improving access to affordable, high-quality health care by mandating all residents have health insurance by July 2007. Following health care reform, residents with incomes less than or equal to 300% of the federal poverty level who are not Medicaid or Medicare eligible or do not have employer-sponsored insurance are able to enroll in government-subsidized private insurance plans called Commonwealth Care. Massachusetts' groundbreaking effort to expand access to health care for its residents offers a unique opportunity to examine how health care reform affects women and their access to services.

Ibis Reproductive Health and the Massachusetts Department of Public Health (MDPH) Family Planning Program collaborated to investigate how this landmark legislation affected low-income women's access to contraception. Our project aimed to document the perspectives and experiences of low-income women seeking contraceptive services and of MDPH-funded family planning agencies and clinics providing contraceptive services before and after health care reform in Massachusetts. We also collected data on how Massachusetts health care reform affected women's access to publicly funded and subsidized insurance, and other health care services in addition to contraception.

Methods

From August 2008 through March 2009, we conducted a four part mixed-methods study that included:

- 1) *Systematic review of Commonwealth Care plans*: We reviewed the websites of the four then available Commonwealth Care plans to assess a potential new user's ability to determine her/his eligibility for a plan and access information on reproductive health coverage and cost.
- 2) *Survey of family planning agency staff*: We surveyed senior administrative staff at ten of the 12 MDPH-funded family planning agencies using a self-administered questionnaire. The questionnaire assessed knowledge of and opinions about health care reform and examined the impact of reform on administration and service provision at the agency level.
- 3) *In-depth interviews with family planning agency and clinic staff*: We conducted 16 in-depth interviews with clinic and agency staff (collectively referred to as family planning providers). Interviews assessed knowledge of and opinions about health care reform and examined the impact of reform on administration and service provision at the clinic level.
- 4) *Focus group discussions with low-income women*: We conducted nine English- and Spanish-language focus group discussions with low-income women (defined as women at or below 300% of the federal poverty level). Focus group topics included participants' knowledge of and opinions about health care reform, health insurance history, and experiences with using and obtaining contraceptives before and after health care reform.

Multiple data analysis strategies were used. For the systematic website review, four independent reviewers noted the presence or absence of specific information using pre-determined categories and codes, and input all data into one standardized data collection sheet. Discrepancies in the data collected were resolved where possible by two other investigators. Microsoft Excel was used to calculate frequencies and summary statistics of close-ended and quantitative questions for the website review and agency self-administered survey. Qualitative data from in-depth interviews and focus group discussions were transcribed verbatim, translated (where necessary) into English, and analyzed thematically using a combination of inductive and deductive codes in ATLAS.ti version 5.5.

Results

The family planning providers and women in our study reported both positive and negative opinions about and effects health care reform. Participants reported that overall access to insurance has increased, subsequently increasing access to a variety of affordable health services and prescriptions. They also reported that most low-income family planning clients in Massachusetts continue to have “wicked easy” access to contraceptive services. However, some barriers to accessing contraception remain. Limits to the number of cycles of contraception dispensed at once at pharmacies, inconvenient pharmacy locations, pharmacists’ lack of knowledge about what prescriptions are covered by the new subsidized plans, and even women’s unfamiliarity with how to use prescriptions were named as challenges to contraceptive access for previously uninsured women accustomed to obtaining care from family planning clinics.

Although providers and women reported that overall health care reform has led to many improvements in access to health insurance and health care for women, access to health care has not improved or has gotten worse for some populations of women. Immigrants, young women, those with erratic insurance coverage, and those not living in urban areas have been “left out” of health care reform. We focus below on the populations who have fallen through the cracks of reform.

We identified four main barriers to accessing health care for immigrants: fear of deportation, lack of English language proficiency, inability to legally access any type of insurance plan, and lack of knowledge of the availability of services at public health clinics. These barriers, and a new focus after reform on state residency requirements to be eligible for Commonwealth Care, led some women to stop seeking health care as they feared they’d be fined or deported if it was found they were to be undocumented and with no health insurance. Some women even stopped seeking care from family planning clinics where care is provided regardless of income, insurance or immigration status.

Providers and women reported that young women, though often covered under a parent’s insurance, are unable to access reproductive health care confidentially and therefore sometimes choose to forego health care. Young women also appear to feel less comfortable advocating for themselves when navigating a complex and sometimes bureaucratic health care system.

For some women, eligibility for coverage under health care reform constantly changes as their life circumstances change, causing many women to be pushed on and off the subsidized plans. Women with variable employment, women going through common life changes (*e.g.*, pregnancy, marriage, starting or finishing college, leaving home), and women whose primary residences frequently change faced a number of barriers in maintaining their health insurance. These women were prone to regularly experience gaps in health insurance coverage and were often unaware when their eligibility began and when they have been dropped by a plan.

Finally, women living outside of urban areas experienced challenges finding a provider who accepted their plan and was accepting new clients. Distance to a pharmacy was also noted as a barrier to accessing contraception and other prescription medication. This forced many women to delay seeking care until they could find a provider with availability.

Conclusion

More research is needed to assess whether the findings from this exploratory study reflect the experience of men and women across Massachusetts. However, it seems clear that those populations “left out” of health care reform have encountered significant barriers to accessing health care services. As national reform is modeled on the Massachusetts approach, many of the challenges described here are likely to arise as national implementation efforts move forward. While national reform holds the promise of greatly reducing the number of uninsured, pro-active efforts to ensure consistent access to health care and contraception services for all women during national roll-out are imperative. This study highlights the critical importance of integrating current safety net systems into national health care reform efforts to meet the needs of women who may fall through the cracks or have trouble negotiating the health care system.

Conference website:

<http://familyplanning.uchicago.edu/policy/conferences/conference2011.shtml>